Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-0458-01

MFDR Date Received
October 6, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical center was paid a total of $3,968.44 however our facility was under paid per the APC Rate/Fee schedule. A requestor for reconsideration was submitted on 3/10/10 to the carrier requesting that they re-review all supporting documentation and remit additional payment. Pine Creek Medical center received the denial EOB dated 03/26/10 no additional payment recommended for a Bilateral procedure. Total reimbursement should have been $15,726.91."

Amount in Dispute: $11,758.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our review is as follows: CPT 29888 per CPT description is 'Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction'. The lay description is as follows: The physician makes a portal incision 1 cm long on either side of the inferior patella for arthroscopic access into the knee joint. If the ligament is intact but torn away from its bony attachment, the physician may reattached the ligament with a screw. If the ligament is nonfunctional, it is removed with the arthroscope. For an anterior cruciate ligament reconstruction (**29888**), a 5 cm to **12** cm incision is made on the anterior lower patella and upper tibia. A tunnel is drilled through the tibia into the knee joint. A second tunnel is drilled from inside the knee joint, through the femur. With the aid of the arthroscope for visualization, a new ligament graft is placed in the tibial tunnel and positioned inside the knee joint. The bony ends of the ligament are placed in the tibial and femoral tunnels. The ligament is secured with interference screws in both tunnels. The operative report documents 'repair using electrothermal modification and ArthroCare Wand'. CPT 29888 ws denied as the documentation does not support the level of service billed as the procedure documented as performed and the level of service described by CPT 29888 is not supported. The operative report documents a synovectomy, removal of loose body and chondroplasty of the pattellofemoral compartment, a partial meniscectomy, chondroplasty, removal of loose body and synovectomy of the lateral compartment and a partial meniscectomy, chondroplasty and synovectomy of the medical compartment and thermal treatment of the ACL. CPT 29876 59 was denied as documentation does not support the level of service billed. The 59 modifier was not supported as the operative report documents more extensive procedures performed in the medial and lateral compartment of partial meniscectomy (CPT 29880). According to Medicare Correct Coding/Encoder Pro, CPT 29876 is global to CPT 29880 and should not be separately billed. Liberty Mutual believes that Pine Creek Medical Center has been appropriately reimbursed for services rendered to [injured worker] for the 01/25/21010 date of service."

Response Submitted by: Liberty Mutual Insurance Co., 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2009	Outpatient Surgical Services	$11,758.47	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 4, 2010 and March 26, 2010:
   - 16, X936 – CPT or HCPC is required to determine if services are payable.
   - 150, X901 – Documentation does not support level of service billed.
   - 150, Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.
   - 42, Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 150, X901 – Documentation does not support level of service billed. Review of the submitted documentation supports the insurance carrier's denial.
2. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and

supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- The insurance carrier denied procedure code 29888 with reason code X901 – "Documentation does not support level of service billed." Review of the submitted information finds that the documentation does not support the service as billed. This reason code is supported. Reimbursement is not recommended.
- The insurance carrier denied procedure code 29876-59 with reason code X901 – "Documentation does not support level of service billed." Review of the submitted information finds that the documentation does not support the service as billed. The reason code is supported. Reimbursement is not recommended.
- Procedure code 29880 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,016.77. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,210.06. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $1,177.51. The non-labor related portion is 40% of the APC rate or $806.71. The sum of the labor and non-labor related amounts is $1,984.22. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $1,984.22. This amount multiplied by 200% yields a MAR of $3,968.44.

5. The total recommended payment for the services in dispute is $3,968.44. This amount less the amount previously paid by the insurance carrier of $3,968.44 leaves an amount due of $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 14, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.